Comparing Macro Influences on Individuals' Initial Coping and Response to COVID-19 in Canada and USA

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Abstract

It is a responsibility of national leadership to provide guidance and provisions to their citizens during a pandemic. National responses to the COVID-19 pandemic have greatly varied internationally. The purpose of this study was to compare how people in Canada and the USA coped to the COVID-19 pandemic, with an eye towards discerning if any differences relate to macro systems differences between the neighboring countries. Data were analyzed from an online, cross-sectional survey administered to people ($N=1405$) living in Canada and the USA in June 2020. Significant results show that respondents from Canada were felt more prepared, adapted/coped better to the pandemic, had less life disruption, fewer challenges with healthcare and financially, and were personally less affected by the pandemic than respondents from the USA. Those from Canada also showed significant higher levels of support for both their national and provincial/state leadership and belief in the necessity of preventative measures than those in the USA. Respondents from the USA were more likely to use family and friends as a source of information and as a basis for their personal preventative practices, whereas those in Canada were more likely to follow the official government recommendations. There were no significant differences in methods of coping. These results support the need for a clear role of government and for government to respond to individuals in a way that promotes equity and social justice, and thus, ensuring human rights.

Keywords Comparative analysis · Coping · COVID-19 · Government · Social justice

Responses to the COVID-19 pandemic have varied from country to country, reflecting differences in government structures and policy aims. Examining and learning from these differences from a macro perspective is critical to ensuring that future responses and planning to pandemics preserve human rights. The purpose of this study was to

compare how people in Canada and the USA responded to and coped with the COVID-19 pandemic, and to discern the effects of macro systems differences between the neighboring countries. Sharing nearly 4000 miles of border, it is interesting that these two countries have such varying outcomes to the pandemic.

Although the trajectory of the pandemic is still very much uncertain, it may be safe to say that up until now, Canada fared better than the USA. At the time of this writing, the rate of transmission in Canada was following a linear trend while the USA was witnessing an exponential growth of transmissions (Chimmula & Zhang, 2020). The World Health Organization (WHO) reported 4,323,160 cases in the USA and 114,994 cases in Canada as of July 30, 2020 (WHO, 2020). The USA had among the highest rate of cases (1430 per 100,000 residents), while Canada had a much lower rate of cases at 315 per 100,000 residents (New York Times, 2020).

Despite common beginnings between Canada and the USA (e.g., both countries are: former colonies, populated by waves of immigrants from abroad, have federal regimes,

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and have written constitutions, including protections for individual rights) (Citrin et al., 2012), the two countries are quite distinct today. Canada's own national identity is sometimes overlooked and it is thought of as an "extension" to the USA (Hannay, 2017). However, the uniqueness of Canada is practically impossible to be absorbed by their more populated neighbor to the south. For example, though deeply complex, as a whole, Canada has multiculturalism, while the USA values assimilation and stressing a "melting pot" (Citrin et al., 2012).

The responses to the COVID-19 pandemic from the political structures in each country have been vastly different. A lack of unity and bipartisan agendas have heavily damaged managing the pandemic in the USA. Republicans in the USA relayed skepticism about the severity of the pandemic early, and perhaps as a result, attitudes toward COVID-19 are heavily polarized (Merkley et al., 2020). Strong, decisive national action was imperative at the outbreak; yet, the US federal response has been alarmingly slow to develop, fostering confusion about the nature of the virus and necessary steps to address it (Haffeejee & Mello, 2020). States and localities have been at the leading edge of the response but have unevenly exercised their public health powers (Haffeejee & Mello, 2020). In contrast, Canadian political elites and the public are in a unique period of cross-partisan consensus on important questions related to the COVID-19 pandemic, such as its seriousness and the necessity of social distancing (Merkley et al., 2020).

The highest leadership of each country could not be more different in their response to the pandemic. Elite messaging from the administration of the then U.S. President Trump, downplayed the seriousness of the virus, and may have produced a differential mass public health response among his supporters (Kushner Gadarian et al., 2021). Canadian Prime Minister, Justin Trudeau championed preventative measures as a measure of a shared sense of duty (Cecco, 2020). An illustration of the value differences between the two country's leaders during the pandemic can be found, comically, in their hair. Prime Minister Justin Trudeau followed the rules and did not get a haircut until it was legal for barbershops to operate again in Canada to set an example to the rest of the country. Watching his hair grow during the early stages of the pandemic became a pastime in Canada, while President Donald Trump's hair remained exactly the same. Additionally, President Trump openly refused to wear a mask on several occasions and held large rallies (Liptak & Salama, 2020).

The governments of Canada and the USA do not just differ in their response to the pandemic. These countries have some significant differences and approaches to fundamental human rights in established institutional policies and systems. Although the USA and Canada both signed the Universal Declaration of Human Rights (UDHR) in 1948, the

UDHR is not legally binding. They are guiding principles that align signatory countries together in the context of a united international community, as envisioned in 1948. Since the UDHR laid the foundation for international human rights, there have been nine treaties established to further advance global human rights protections in specific domains and with respect to specific vulnerable populations. Of these nine, the USA has only ratified three, whereas Canada has ratified all nine. Further, of all nine international human rights treaties, the USA has yet to ratify the International Covenant on Economic, Social and Cultural Rights (ICESCR), as opposed to Canada, which was one of the first 29 countries to ratify it. President Carter signed ICESCR in 1977, but the USA has yet to ratify it (Piccard, 2010). Each administration since President Carter (with the exception of the Trump Administration) has attempted to achieve ratification, with varying degrees of rigor and will. Each has failed to obtain the approval of the US Senate, necessary for the ratification of any international treaty (Rengel, 1994). The result is a grave disregard for the 38 million people living in poverty in the USA in 2018, and in need of a government committed to ensuring and protecting such rights as health, education, housing, and a living wage for all people (Poverty USA, 2020).

These varying perspectives to human rights in general also impact people's ability to adjust to in the face of the COVID-19 pandemic. Pre-pandemic, services such as healthcare and childcare have also been provided on varying levels between the two countries. With the exception of non-emergency dental and vision care, universal healthcare is available in Canada, while health insurance in the USA for all forms of care is overwhelmingly obtained through private (mostly employer-based) means (Siddiqi et al., 2009). With regard to childcare policy, Canada falls under the liberal categorization (Pasolli, 2015) and provides the Canada Child Benefit to all citizens with children. This program provides a maximum annual benefit of \$6400 per child under the age of six and \$5400 per child aged 6 through 17. The benefit is tax-free and paid monthly to eligible families (Canada, 2020). In the USA, with the Child Tax Credit, a person can reduce their federal income tax by up to \$1000 for each qualifying child under the age of 17 (IRS, 2011).

For financial assistance specific to the pandemic, in effort to assist those who have been impacted, both the USA and Canada have distributed stimulus funds. The government of Canada has developed the Canada Emergency Response Benefit (CERB). The CERB ensures relief to individuals, businesses, and organizations facing hardship during COVID-19 multiple benefit packages. This benefit is dispersed by the Canada Revenue agency and must be applied for on a monthly basis. The provision is given to laid off workers and employed staff who have experienced a reduction in their work hours due to COVID-19. If found eligible, an individual will receive \$2000 over a 4-week

period. After the 4-week timeframe, eligible Canadians would have to reapply for the funds for repeat payment up to 24 weeks (Government of Canada, 2020). In contrast, the United States Congress approved the Coronavirus Aide, Relief and Economic Security (CARES) ACT of 2020, which has distributed a one-time issuance of \$1200 per adult, \$500 per child under 17 years of age, and an additional \$600 weekly for eligible unemployment participants. Other provisions were provided to state, local and tribal governments, small businesses (as grants and loans), as well as assistance to employers to maintain their workforce (US Department of the Treasury, 2020).

Canada and the USA faced the COVID-19 pandemic at the same time and in the same geographic region. However, their differing human rights policy and cultural responses reflect differing societal values. This article aims to explore how these different policies and values are reflected in the responses of the people of these two countries. As social workers, we understand that these macro influences impact individuals greatly, and it is our responsibility to examine macro differences. By doing so, we are able to better plan and advocate for intervention and change.

Methods

The researchers' home institutional review boards approved this study prior to survey distribution. This study involved an anonymous, cross-sectional survey administered online through Qualtrics Survey Software. Data were collected in June 2020 and targeted adults living in Canada and the USA. Informed consent was provided in the introduction of the survey, and completion of the survey was considered consent for participation. Survey completion took about 10 min or less.

Participants were recruited through convenience and snowball sampling, using researchers' personal contacts, social media, and personal and professional networks. There were additional efforts made to reach underrepresented populations and geographic areas by inviting known contacts from those communities to share the survey.

The survey consisted of 30 researcher-constructed items using a six-point Likert-type scale. The items asked respondents to indicate their level of agreement to statements concerning the COVID-19 outbreak (1 = *strongly disagree*, 6 = *strongly agree*), such as "I am satisfied with our national leadership's response during this COVID-19 outbreak" and "I experienced challenges related to medical care during the COVID-19 outbreak".

Respondents were also asked to provide various demographics including age, gender identity, race and ethnicity, political ideology identification, educational attainment, number of children living in the home, age categories of

children living in the home, number of adults living in the home, state/province, and their geographic setting.

Results

Representation from all 50 states in the USA and all nine English-speaking Canadian provinces (all provinces except Quebec) was obtained, with 1405 people responding to the survey, with 79 respondents from Canada and 1311 respondents from the USA. Responses from Canada represented approximately 6% of the total sample; about half as many as would be representative of the comparative populations. The population estimates for July 1, 2019 were 37,589,262 for Canada (The Daily, 2019) and 328,239,523 for the USA (United States Census Bureau, 2020), making the actual Canadian population to be estimated at 11.5% of the population in the USA. See Table 1 for a summary of the socio-demographic characteristics of the sample.

The data were analyzed using SPSS and SPSS. Bivariate analyses were conducted for all survey items to determine differences between those living in Canada and the USA. *t* tests found respondents in Canada were more likely to agree that they felt prepared for the COVID-19 outbreak ($M=2.85$, $sd=1.61$), as compared to respondents in the USA ($M=2.48$, $sd=1.58$), $t(1384)=1.98$, $p=.047$. Respondents in Canada were less likely to agree that they experienced serious life disruption by the COVID-19 ($M=4.68$, $sd=1.48$) than respondents in the USA ($M=5.07$, $sd=1.32$), $t(1316)=-2.55$, $p=0.011$. Respondents in Canada were less likely to be personally affected by the virus itself ($M=1.78$, $sd=1.42$) as compared to respondents in the USA ($M=3.47$, $sd=1.92$), $t(1335)=-7.41$, $p=0$. Respondents in Canada were more likely to agree that they were adapting and coping well to the COVID-19 outbreak ($M=4.71$, $sd=1.91$) than respondents in the USA ($M=4.32$, $sd=1.37$), $t(1309)=2.36$, $p=.02$.

Additional differences between participants from Canada and the USA were found in their views of leadership and government. Respondents from Canada ($M=5.06$, $sd=1.31$) were more likely to be satisfied with their national leadership's response to the pandemic than respondents from the USA ($M=1.93$, $sd=1.54$), $t(1301)=16.9$, $p=0$, and satisfied with provincial/state leadership (Canada: $M=4.98$, $sd=1.3$; USA: $M=4.34$, $sd=1.64$), $t(1361)=2.88$, $p=0.004$. Further, respondents from Canada ($M=5.09$, $sd=1.33$) were more likely to agree with their government's recommended preventative measures than respondents from the USA ($M=4.71$, $sd=1.29$), $t(1376)=2.54$, $p=0.011$, and to base their personal preventative measures on government official recommendations (Canada: $M=5.09$, $sd=1.33$), as compared to respondents from the USA ($M=4.71$, $sd=1.29$), $t(1376)=2.54$, $p=0.011$.

Table 1 Demographics for overall sample, Canada and US respondents ($N=1405$)

Demographic*	Sample M (SD)/%	Canada M (SD)/%	USA M (SD)/%
Age	43.04 (24.09)	54.46 (9.84)	42.27 (24.52)
Gender identity			
Female	82.6	78.5	82.8
Male	16.2	20.3	15.9
Other	1.2	1.2	1.3
Race/ethnicity*			
American Indian/First Nations	.8	2.5	.8
Asian	2.9	2.5	3.0
Black or African-American	9.2	0	9.8
Hispanic, Latino or Spanish origin	7.0	0	7.4
Middle Eastern or North African	1.2	0	1.3
Multiracial	5.2	0	5.5
Native Hawaiian or other Pacific Islander	.4	0	.5
White	81.4	94.9	81.4
Other	1.8	0	1.8
Education			
Less than HS diploma	.1	0	.1
HS diploma or GED	22.5	19	22.8
Associate's degree	7.2	16.5	6.6
Bachelor's degree	22.8	35.4	22.1
Master's degree	33.5	25.3	34
Doctoral degree or PhD	13.8	3	13.8
Political views			
Extremely conservative	1.8	2.5	1.8
Moderately conservative	11.6	11.4	11.6
Neither conservative or liberal	23.4	22.8	23.5
Moderately liberal	40.3	43.0	40.2
Extremely liberal	22.8	20.3	23
Geographic location			
Large city	23.2	14.3	23.8
Small city	14.7	33.8	13.6
Suburban	30	7.8	31.3
Town	20.9	15.6	21.2
Rural	10.8	28.6	9.8
Other	.4	0	.3

*More than one option could be selected

Respondents from the USA were more likely to experience challenges in certain areas than those from Canada. A t test found a significant difference in the level of agreement with the statement “I experienced medical care challenges related to the following during the Covid-19 outbreak,” depending on whether the respondent lived in Canada ($M=2.83$, $sd=1.89$), compared to the USA ($M=3.49$, $sd=1.86$, $t(1240)=-2.89$, $p=0.004$, and “I experienced financial challenges related to the following during the Covid-19 outbreak,” depending on whether the respondent lived in Canada ($M=2.86$, $sd=1.91$), compared to the USA ($M=3.41$, $sd=1.91$), $t(1255)=-2.37$, $p=0.018$.

There were significant differences in some of their sources of information and support during the pandemic. Those living in USA ($M=4.18$, $sd=1.47$) were more likely to use friends and family as a source of information than respondents in Canada ($M=3.81$, $sd=1.56$), $t(1315)=-2.01$, $p=0.045$. On the other hand, respondents in Canada ($M=3.85$, $sd=1.84$) were more likely to use the radio as a source of information than those living in the USA ($M=2.99$, $sd=1.84$), $t(1208)=3.72$, $p=0$. Lastly, there were no significant differences between the respondents from Canada and the USA in their coping mechanisms (e.g., religion, family and friends, exercise). Table 2 displays the results for all items.

Table 2 Survey items and descriptive statistics

Item, location (<i>n</i>)	<i>M</i> (<i>SD</i>)	<i>t</i> (<i>df</i>)	<i>p</i>	Cohen's <i>d</i>
I felt prepared for the COVID-19 outbreak				
Canada (79)	2.85 (1.61)	1.98	.047	.9
USA (1307)	4.28 (1.58)	(1384)		
I read the newspaper (either hardcopy or online) as a source of information on the COVID-19 outbreak				
Canada (70)	3.44 (2.05)	−1.22	.23	
USA (1219)	3.74 (2.00)	(1287)		
I used social media as a source of information on the COVID-19 outbreak				
Canada (74)	4.49 (1.49)	−.26	.8	
USA (1244)	4.54 (1.6)	(1316)		
I used the news on TV/internet as a source of information on the COVID-19 outbreak				
Canada (77)	4.53 (1.71)	.29	.77	
USA (1238)	4.47 (1.72)	(1313)		
I used family/friends as a source of information on the COVID-19 outbreak				
Canada (69)	3.81 (1.56)	−2.01	.045	.24
USA (1248)	4.18 (1.47)	(1315)		
I used the radio as a source of information on the COVID-19 outbreak				
Canada (67)	3.85 (1.84)	3.72	0	.47
USA (1143)	2.99 (1.84)	(1208)		
My life was significantly disrupted by the COVID-19 outbreak				
Canada (77)	4.68 (1.48)	−2.29	.02	.28
USA (1241)	5.07 (1.32)	(86.6)		
I was personally affected by the virus itself (e.g. personally contracted the virus, knowing people who have died, knowing many people in my community having it, etc.)				
Canada (74)	1.78 (1.42)	−9.71	0	1
Rural /Town (1263)	3.47 (1.92)	(90)		
I experienced challenges related to medical care during the COVID-19 outbreak				
Canada (69)	2.83 (1.89)	−2.89	.004	.35
USA (1173)	3.49 (1.86)	(1240)		
I experienced challenges related to childcare during the COVID-19 outbreak				
Canada (32)	2.47 (2.12)	−1.12	.27	
USA (648)	2.91 (2.19)	(678)		
I experienced challenges related to transportation during the COVID-19 outbreak				
Canada (61)	2.03 (1.69)	−1.02	.31	
USA (956)	2.27 (1.8)	(1015)		
I experienced challenges related to work during the COVID-19 outbreak				
Canada (63)	4.62 (1.71)	−.18	.86	
USA (1158)	4.66 (1.71)	(1219)		
I experienced financial challenges during the COVID-19 outbreak				
Canada (70)	2.86 (1.91)	−2.37	.02	.29
USA (1187)	3.41 (1.91)	(1255)		
I adapted to/coped with the COVID-19 outbreak very well				
Canada (75)	4.71 (1.31)	2.36	.02	.29
USA (1236)	4.32 (1.37)	(1304)		
I am able to evaluate information about COVID-19 based on the quality and source of the information				
Canada (79)	4.97 (1.33)	.21	.83	
USA (1297)	4.95 (1.13)	(1374)		

Table 2 (continued)

Item, location (<i>n</i>)	<i>M</i> (<i>SD</i>)	<i>t</i> (<i>df</i>)	<i>p</i>	Cohen's <i>d</i>
I felt overwhelmed by the amount of information available about the COVID-19 outbreak				
Canada (79)	4.15 (1.52)	−.14	.9	
USA (1308)	4.18 (1.61)	(1385)		
My family/friends provided support to me during the COVID-19 outbreak				
Canada (76)	5.16 (1.32)	−1.5	.14	
USA (1299)	5.41 (1.02)	(79)		
My child(ren)'s school provided support to me during the COVID-19 outbreak: -				
Canada (31)	3.16 (1.66)	−1.18	.24	
USA (621)	3.55 (1.8)	(650)		
My religion/faith provided support to me during the COVID-19 outbreak				
Canada (50)	3.58 (2.11)	−1.37	.18	
USA (934)	4.00 (1.82)	(53)		
My religious community provided support to me during the COVID-19 outbreak				
Canada (45)	3.13 (2.03)	−1.37	.17	
USA (819)	3.53 (1.87)	(862)		
Social media provided support to me during the COVID-19 outbreak				
Canada (77)	3.69 (1.34)	−.53	.6	
USA (1251)	3.78 (1.53)	(1326)		
Alcohol and substances provided support to me during the COVID-19 outbreak				
Canada (65)	2.58 (1.67)	.2	.84	
USA (1033)	2.54 (1.72)	(1096)		
Exercise provided support to me during the COVID-19 outbreak				
Canada (76)	4.54 (1.53)	.78	.43	
USA (1222)	4.39 (1.6)	(1296)		
Mind/body practices (yoga, tai chi, meditation) provided support to me during the COVID-19 outbreak				
Canada (61)	3.93 (1.63)	.8	.43	
USA (1035)	3.76 (1.77)	(69)		
I am satisfied with our national leadership's response during this COVID-19 outbreak				
Canada (72)	5.06 (1.31)	19.8	0	2.19
USA (1231)	1.93 (1.54)	(83)		
I am satisfied with my state governor's response during this COVID-19 outbreak				
Canada (56)	4.98 (1.3)	3.6	.001	.43
USA (1307)	4.34 (1.64)	(63)		
I believe the measures taken by leadership (e.g., school closures, business closures, re-opening) were appropriate to the level of risk in my community				
Canada (78)	5.22 (1.21)	3.41	.001	.37
USA (1311)	4.73 (1.46)	(91)		
I strictly followed my state's preventative measures (e.g., social distancing, wearing a mask) during this COVID-19 outbreak				
Canada (75)	5.55 (1)	.48	.63	
USA (1310)	5.49 (1.06)	(1383)		
I based my personal preventative measures on government officials' recommendations				
Canada (79)	5.09 (1.33)	2.54	.01	.29
USA (1299)	4.71 (1.29)	(1376)		
I based my personal preventative measures on family's and friends' recommendations				
Canada (79)	3.34 (1.57)	−1.75	.08	.2
USA (1296)	3.66 (1.58)	(1373)		

Discussion

The extent to which government and other official sources invest in mechanisms to support people is critical. This study explored whether residence in Canada or the USA may be a factor that contributed to people's ability to adapt and cope with the COVID-19 pandemic. Overall, respondents in Canada seemed to fare better than their counterparts south of the border in the USA. Respondents from Canada felt more prepared for the pandemic, expressed adapting/coping better, experienced less disruption, and felt less personally affected by the virus than respondents from the USA. The more cohesive and unified national response in Canada could be a possible reason for this finding. The politically unified nature of the Canadian governmental response could also explain why respondents were also more satisfied with both their national and provincial leadership during the pandemic, as well as impact their higher level of trust in the preventative measures prescribed by their government.

When there is a higher level of trust in the government, there may be less of a need to rely on family and friends. This theory would support the finding that respondents from Canada were more likely to base their personal preventative measures on government officials' recommendations than those from the USA were, while those from the USA were more likely to base their personal preventative measures on the advice of their family and friends than those from Canada. This theory would also explain the findings that respondents from Canada were more likely to use the radio as a source of information, while respondents from the USA were more likely to use their friends and family as a source of information.

It is unclear why those from Canada used the radio as a source of information more than those from the USA. Generally speaking, radio listening between the two countries seems comparable. When asked about their use of radio and audio services in 2017, 88% of Canadians 18 years and older reported listening to the radio in any given month (Canadian Radio-television & Telecommunications Commission, 2018), while 91% of Americans 12 and older in 2016 listened to the radio (Pew Research Center, 2017). It is possible that the radio in Canada is more news-based. It has been found that news provided more accurate information about COVID-19 than social media does (Bridgman et al., 2020). It is also possible that those in the USA sought out guidance from friends and family through social media, which may explain varying degrees of preventative measures, and thus lowering the ability to overall decrease COVID cases. This finding warrants closer examination, which may include types of radio stations listened to and more specified frequency of listening.

In sum, this study shows that respondents to the present survey from Canada seem to fare better during the onset of

the pandemic than their counterparts in the USA. Although all countries have strengths and challenges, these differences in overall well-being may reflect generally better quality of life for Canadians. The Institute for Economics and Peace (2020) ranked Canada sixth in the world for peace, and the USA at 121. Canada also outranks the USA in the areas of life expectancy, environment, community, education, health, life satisfaction, and safety. At the same time, the USA tops Canada in jobs, income, and housing (Organisation for Economic Co-operation and Development, 2020). These indicators of well-being provide insight into what was found in this study in that Americans may have been "hit harder" in the areas of money and finances, while Canadians enjoy an overall higher quality of life in the areas of fundamental rights, such as healthcare. Although universal healthcare is not flawless, easier access to healthcare in Canada may have contributed to fewer challenges expressed by respondents from Canada than respondents in the USA. Access to healthcare is a basic human right, and not a human "need" (McPherson, 2020). Unfortunately, the USA has not been champion for human rights for quite some time (Mapp & Gabel, 2019). It is time for social workers in the USA to take strong action in these areas, in order to fulfill a basic human right in the profession's pursuit of social justice.

Lastly, there were no significant differences in the personal sources of support and coping between respondents from the two countries. All in differences in survey results in this study are related to the macro level, which points to the need for change at the macro level to better address the COVID-19 pandemic. Not all people trust governments equally (Fernandes & Patten, 2019), and overall, Canada ranks higher than the USA in resident trust in government, NGO's, businesses, and media (Edelman, 2020). It should be noted, however, that distrust in government can lead to productive outcomes. One study found that somewhere between critical trust and distrust lie the higher likelihood of civic engagement (Parkins et al., 2017). If we as social workers can capitalize on times and areas where public distrust is growing, we may be able to mobilize in ways that move towards human rights, transparency, respect, and social equality. It is the times like these where we recognize the flaws in our systems and policies that we undergo a transformative consciousness to move towards a healthier and more just society (Jemal, 2018).

There are some limitations to this study that are worth noting. First, although representation was obtained from all 50 states and provinces (except Quebec), there was not equal distribution geographically. Most of the responses were concentrated in the Northeast of the USA, and in the Maritimes for Canada. The convenience/snowball sampling method employed does not suggest generalizability beyond the sample. The study sample had a very high proportion

of women, over-representation of White respondents, and higher educational levels than found in the general US and Canadian populations.

Additionally, the nature of online surveys cannot ensure that a person did not intentionally or unintentionally complete the survey more than once. Access to participation is only available to those with Internet capacity, which may be an economic bias. Despite these limitations, the findings of this study provide support and insight as to how different structures impact coping during this time and can inform additional explorations of difference between the responses to the pandemic from Canada and the USA. All this can further social work's mission to achieve human rights, social justice, and equality.

Declarations

Ethical Approvals Granted by Yeshiva University.

Consent to Participate Completion was considered consent and stated in the introduction of survey.

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